PUBLIC HEALTH, WELFARE & SAFETY
Exhibit No. 2
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Billings Clinic

2800 Tenth Avenue North
PO Box 37000
Billings, MT 59107-7000

Testimony before the
Senate Public Health, Welfare, and Safety Committee

January 14, 2009

Senator Brown and members of the Senate Public Health, Welfare, and Safety Committee, for the record my name is Dr. Nicholas Wolter, CEO of Billings Clinic and chair of MHA – better known as the Montana Hospital Association.

Billings Clinic is a not for profit health care organization, providing hospital and clinic services to the nearly 600,000 residents of eastern and south central Montana, northern Wyoming, and the western Dakotas. Thank you for the opportunity to contribute to this committee's efforts to examine solutions to improve the access and affordability of health care in Montana.

MHA has been actively working with Senator Baucus and his staff as they advance their Call to Action Health Care Reform 2009 agenda, contributing ideas that are relevant and unique to Montana's health care landscape.

Last year, I finished a six year appointment to MedPAC—a 17 member independent Congressional agency established by the Balanced Budget Act of 1997—charged with advising Congress on Medicare payment policy, as well as analyzing access to care, quality of care, and other issues affecting Medicare. This experience reinforces to me that efforts to improve access and affordability of health care in Montana should consider and complement the Federal reform agenda.

I've been asked to include in my remarks those Montana Health Care Forum recommendations that MHA supports. I've referenced them in the context of the three broad areas in which I've organized my thoughts.

Coverage for All to Affordable Health Care

Montana policymakers have pursued an incremental approach over the past two decades to reduce the number of uninsured Montanans. Both public and private market initiatives have been enacted. You'll have the opportunity this session to evaluate their success and sustain and/or grow those investments. Ensuring health care coverage, especially for children, the most vulnerable segment of our population is the first guiding principle for Billings Clinic's advocacy efforts. We believe that the legislature should fully fund the Healthy Montana Kids Plan, which was authorized by the ballot initiative I-155.

Federal reform efforts propose to extend and build on the tradition and success of employer-sponsored insurance. Insure Montana, created in the 2006 Legislative Session, provides tax credits and premium payments to help small business owners provide health insurance to their employees. Insure Montana currently covers almost 4000 people in the purchasing pool and provides tax credits to businesses to help provide coverage to more than 4000 additional individuals. Approximately 500 businesses are on the waiting list. This program has been successful and legislators should ensure its sustainability and give strong consideration to expanded funding to reduce the waiting list of businesses desiring to participate in the purchasing tool and ensure that affordable health premiums are available for low income participants.

In order to truly change the ever increasing costs of health care, the United States must dramatically shift its health care focus to preventing chronic lifestyle related disease. Individuals must take a greater role and accountability to be informed and be active participants in their health care.

In response to discussions about empowering greater consumerism and health care pricing transparency at the Montana Children, Families, Health and Human Services Interim Committee, MHA has developed and launched a Web site—Montana Informed Patient—which places Montana hospital prices, information about the quality of care and other consumer information online. Policy makers can support SJ5—Continued interim monitoring of health care pricing and information disclosure, Rick Laible, primary sponsor—this session that will help to sustain momentum and urge insurers and physicians to add to this consumer health care resource.

The 2009 Legislature this session has again the opportunity to enact sound public health policy and should support primary enforcement of seat belt and child safety seat usage. This will result in medical saving to the State of Montana of about $14 million general fund per year. You will hear new research data utilizing data from Montana Trauma Registry during hearings to support this statement.

Delivery System Reform

The Institute of Medicine, in its seminal work *Crossing the Quality Chasm,* emphasized that the fragmented health care delivery system yields a complex morass that is difficult for patients to navigate and produces care that is largely uncoordinated, inefficient, often of questionable effectiveness, and with great geographical variation in treatment and utilization. Numerous structural changes are needed. MedPAC has outlined certain desired activities, i.e., use of evidence based medicine, care coordination, information technology use, that if rewarded through payment mechanisms, would encourage more integrated forms of care and begin a shift away from volume-based payments that contribute to fragmented and often unnecessary care.

Nationally, this reform concept is known as Accountable Care Organizations—promoting accountability for quality and resource use over an extended period of time for a population of patients. In ACOs, physicians and hospitals would be incentivized to work together and improve care coordination, control growth in the volume of services, and improve their quality.

Billings Clinic is pleased that we were able to work with the department of Public Health and Human Service's Senior and Long Term Care Division to begin offering PACE (Program of All-Inclusive Care for the Elderly) services to frail elderly in Billings and Livingston financed through bundled capitated payment, pooling Medicaid and Medicare dollars to coordinate/provide all health care services to seniors that meet nursing home eligibility criteria. PACE expands on the legislatures' long standing support of home and community based waiver services, which you will have an opportunity to reaffirm this session. I would encourage this committee to support payer innovations that encourage more coordination of care between hospitals and physicians.

Another concept in delivery system reform is strengthening the role of primary care through both increasing the supply and appropriately valuing their services. This is especially relevant in a rural state like Montana where often primary care is the only medical provider in the community. Our community health centers, a key part of the safety net in many communities, also rely on these practitioners to provide the preventive and primary care services. Primary care includes physicians, i.e., family medicine, pediatrics, and advanced nurse practitioners and physician assistants.

Montana Legislators have the ability to invest in primary care workforce development and retention. Last session, the Legislature expanded the loan repayment opportunities for physicians working in rural and underserved areas. But much more needs to be done to meet our future health care provider needs.

During the interim, the Children, Families, Health and Human Services Committee completed a study of the public mental health system. It acknowledged that a majority of mental health services in our state are provided in the primary care medical setting. We have started to invest in collaborative community crisis intervention services in this state. There is an interdependence between adequate primary care supply and the mental health crisis safety net.

Investing in Health Information technology is an enabler of care coordination and can reduce unnecessary tests and improve patient safety and care quality.

MHA believes that significant cost savings can be achieved by making the current health care system more focused on quality of care and more efficient. There are a number of ideas being discussed at the national level in this area – including paying providers based on the quality of care they provide, investing in better coordination of care, providing incentives to reduce readmission rates and bundling payments for each episode of care.

Most of these proposals are in the development stage, but are certain to be a central feature in the delivery system debate at the national level.

Aligning the Financing System

How can Montana lawmakers influence through their decisions, and contribute to financing reform?

Ensure Medicaid reimbursement covers the cost of providing care by supporting adequate provider reimbursement rates with annual increases that approach medical inflation interrupts care, labor costs, drugs, and supplies. In addition to the various reimbursement schedules for providers, as a state, we've been forward thinking in maximizing the full Federal support of Medicaid through nursing home and hospital utilization fees. This session MHA's highest priority is working to ensure the Hospital Utilization Fee becomes permanent. HB 71—remove sunset on hospital bed tax allowing state to match these dollars with Federal money and helps ensure Medicaid approaches covering cost of proving these services. This is critical in a small business state that can ill afford cost shifting.

National health policymakers understand that payment systems must align and drive accountability for patient safety, quality, and cost. As I mentioned above, payment methodologies, that encourage hospitals and physicians to collaborate on care, include bundled payments—reimbursement of physician and hospital services over an episode of care—i.e., cardiac bypass graft surgery, hip replacement. Focusing payment reform on high volume and high cost cases has the potential for real cost savings to the system.

Billings Clinic has been participating with ten other large physician group practices in Medicare's Physician Group Practice Demonstration, now in its fourth year. The PGP demonstration is demonstrating better coordination of care and quality for the chronically ill and reducing costs to the Medicare system. Expansion of the demonstration project is seen as consistent with other delivery system reforms, such as greater adoption of health information technology and transparency regarding provider quality and costs.

One area that would help providers control their costs is reducing the complexity of the financing system. Administrative simplification of claims processing, billing, data reporting and complying with regulations at the national and state levels would reduce a health care organizations overhead expense.

Montana legislators can also help ensure a fair market place. Self referral to physician owned hospitals encourages selection of healthier, less complex, and insured patients for higher reimbursement. This shifts patient care away from community hospitals and harms the safety net, threatening the community hospitals' ability to provide services that are typically subsidized, emergency department, psychiatric services, and neonatology units.

The Congressional Budget Office has recognized how self referral affects patient care and Medicare reimbursement in its budget estimate and has concluded that enactment of a ban on physician self referral would lead to significant cost savings. Research shows that physician ownership and self referral significantly increases utilization and does not lead to improved outcomes.

Montana has legislation in place that has placed a moratorium on specialty hospitals. That statue expires in June 2009. The Senate Finance Committee is currently considering this issue for inclusion in the economic stimulus package.

In conclusion, I have tried in my comments to touch on three big ideas and tried to connect how legislation before this session is compatible with these concepts.

1. Coverage for all to affordable health care
2. Delivery system reform
3. Aligning our financing systems

This session you have the opportunity to sustain and build on the past legislative efforts to reduce the uninsured and make health care more affordable. It will take sustained commitment and an infrastructure to evaluate our progress. SB 44, which will be heard in this committee on Friday, proposes a Health Policy Council.

Thank you for the opportunity to share my thoughts. I look forward to answering any questions later.

NICHOLAS WOLTER, M.D.

CURRICULUM VITAE

1997 – Present	**Chief Executive Officer** **Billings Clinic** **2800 Tenth Avenue North** **Billings, Montana 59101** **Phone: 406-238-2609** **Fax: 406-238-2785** **e-mail: nwolter@billingsclinic.org**
1993 – 1997	**Physician/Medical Executive Officer** **Deaconess Billings Clinic**
1989 – 1993	**Chairman, Billings Clinic Partnership**
1982 – Present	**Pulmonary and Critical Care Physician** **Billings Clinic**
1987 – 1993	**Medical Director, Critical Care Unit** **Deaconess Medical Center** **Billings, Montana**
1980 – 1982	**Fellowship, Pulmonary and Critical Care Medicine** **University of Michigan Medical Center** **Ann Arbor, Michigan**
1977 – 1980	**Residency, Internal Medicine** **Mary Imogene Bassett Hospital** **Affiliated with Columbia University** **Cooperstown, New York**
1977	**M.D., University of Michigan Medical School** **Ann Arbor, Michigan**
1974	**M.A., American Culture** **Rackham School of Graduate Studies** **University of Michigan** **Ann Arbor, Michigan**
1969	**B.A., English** **Carleton College** **Northfield, Minnesota**

Certifications:

Diplomate, American Board of Internal Medicine
Board Certified, Pulmonary Medicine Subspecialty

Professional Associations:

American College of Chest Physicians
American Thoracic Society
American College of Physician Executives
American College of Healthcare Executives
Montana Medical Association
American Medical Association

Board Activity:

American Hospital Association, 2007-present
American Hospital Association Regional Policy Board 8, Alternate, 2005-present
American Medical Group Association, 2006-present
MHA, An Association of Montana Health Care Providers, 1997-present;
Chair: 9/2002-9/2003
VHA Mountain States, 1995-present; Chair: 2001, 2002
VHA Health Foundation, 2002-2006
New West Health Services, 1998-present; Chair: 1998-2001
Life Center Northwest (Organ procurement agency for
Montana, Idaho, Washington, Alaska), 1997-2006
Medicare Payment Advisory Commission (MedPAC), 2002-present
Northern Rockies Radiation Oncology Center, 1997-present
Plexus Institute, 2001-2004
Rocky Mountain College, 1999-2002

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Data Request
Montana State Senate Public Health, Welfare, and Safety Committee
January 14, 2009

- Total number of employees (as of 9/30/08) – 3494 which includes 228 physicians
  - 3306 employees in our Billings location
  - 188 employees in our Bozeman, Cody, WY, Colstrip, Columbus, Miles City, Red Lodge and Sheridan, WY locations

- Payroll FY08 – $201,497,116

- Annual Revenues and expenses for past two years

	FY07	FY08
Gross patient service revenue	688,787,293	763,779,180
Contractuals	320,244,909	352,148,136
Net patient service revenue	368,542,384	411,631,044
Other revenue	18,287,634	18,178,974
Total operating revenue	386,830,018	429,810,018
Total operating expenses	375,507,773	420,386,652

Our overall reimbursement, which includes revenue from all payers, private and public, versus costs is 106%. This is not a straightforward calculation, but attempts to reduce expenses not directly related to patient care. In general, Medicare and Medicaid reimbursement do not cover our costs, and private insurer reimbursement exceeds our costs.

Jackson, Lisa Mecklenberg

PUBLIC HEALTH, WELFARE & SAFETY

Exhibit No._____

Date_____

Bill No._____

From: jim crichton [jameswcrichton@yahoo.com]
Sent: Saturday, January 10, 2009 11:30 AM
To: Jackson, Lisa Mecklenberg
Cc: Brian Zins; Kirk Stoner; Kurt T. Kubicka M. D.
Subject: Senator Roy Brown's letter

Dear Ms. Jackson,
As you see in the emails, Brian Zins has forwarded request for input from the MMA to the Executive Committee. I have read Senator Brown's letter of request for input and the Independent Record story. I applaud Senator Brown's method of having a few knowledgeable people present for an intense discussion of the topic of improving the quality, access, and fiscal status of Montana's health care system. In the proposed meeting format, it would be better if any ideas of individual MMA members came through Dr. Stoner, but Mr. Zins recommended that I email this to you as time is short. As you see above, I have copied them with this. Senator Brown asked for some personal information from respondants.

I was born in Deer Lodge, MT. I was first licensed to practice in Montana in 1969. After finishing military service and residency training, I practiced in Helena until I retired two years ago. I have been president of the Montana Academy of Family Physicians, Chief of Staff at St Peters Hospital, and Medical Director of Blue Cross Blue Shield of Montana. Currently, I work as a part time consultant at Blue Cross Blue Shield and serve on the Medicaide Drug Utilization and Review Committee. I have seen many earnest attempts by all of these entities to improve health care in our state and in our nation. Some things have occurred to me.

1. There is no simple solution. Government, the individual citizen, (patient), third party payers, physicians, and hospitals will all have to make some changes. Many of us still think that persuading each entity would give a better solution than a top down mandate from the Federal Government.

2.More and more often, we hear the assertion that "health care is a right." I have examined the U.S. Constitution and the Montana Constitution and find that these documents enumerate many rights, liberties, and freedoms, oportunities, and the right to life liberty and the pursuit of happiness. Nowhere do I see that the citizen has a right to expect any specific financial benefit such as health care.

3. An Argument that starts with a faulty premise will lead to an invalid conclusion. Let us discard the faulty premise that health care is a right and find a better premise. I suggest the premise that we are spending more than enough money to have a good health care system, but some of the money is misspent and some is mal distributed.

4. Government at various levels already pays for about half of all healthcare in the US. Medicare, Medicaide, Veterans, IHS, Tricare, SCHIP, Community Health Centers, and others that I either have forgotten or don't know about. The Feds should crunch these together into one before covering every American. The Medicare and Medicaide models have evolved a great deal in the 40 years they have been in place, and there is much to be said for them.

5. Insurance companies lose money by developing numerous and incomprehensibly complex products and procedures. (Medicare has only one benefit package and no sales force). That alone saves 20%, in my opinion.

6. Hospitals mistakenly believe that beautiful bricks and mortar equal high quality health care. Perhaps, a beautiful building is easier to achieve than a staff of competent, content, and caring, professionals. Montana hospitals squander tens of millions of dollars that should be spent on actual health care instead of building beautiful buildings.

7. Physicians face pressures unthinkable a few years ago. These range from lawsuits, new kinds of competition, and several other factors that work to make today's physician only about half to two thirds as productive as he was twenty years ago. This leads to fee building and higher fees and unhappiness all the way around.

8. Patients, usually do not know anything about the above. They do not know the difference between insurance and prepaid health care. In President Bush's Medicare Improvement Act is the provision for high deductible coverage linked to Medical Savings Accounts. This mode has not been encouraged. Over the short term, it is less profitable for insurance companies. The average American thinks of finances in terms of days or weeks, not years. It is not widely known that less than 5% of people will have health care costs in one year that are greater than the amount of their premiums. In the insurance world, it is better to insure the unpredictable 5% chance of disaster and pay the 95% with one's own funds, *i.e.* Medical Savings Account. The power of this idea comes from reattaching medical decision making to someone's wallet. It would do a lot to improve the complex and sometimes felonious billing that we see every day, if at the end of a service, a bill had to be produced that would be understandable, fair, presented to the patient instead of a third party, and paid right then from a medical savings account, maybe with a credit card attached to the account.

9.The heavy hand of Government should be applied to make high deductible/ Medical Saving Account coverage available at its actual cost. Gov't. Should devise better isusrance products that are simple, few, and understandable, and that explain and allow acceptable risk .The insurance companies should be asked to participate, but not dominate. All hospital bills in Montana should be paid on a DRG like system that fairly reimburses actual costs to the non profit hospitals, but doesn't allow for pie in the sky building programs and other excesses. Physicians' fees are well controlled by the RBRVS. Physicians would be more cooperative in the overall effort if the system were a little more physician friendly. Allof this would require a massive education program.

Respectfully submitted,
James W. Crichton, M.D.